South Perth Hospital

Request to Amend Health Information

SURNAME	UMRN
GIVEN NAMES	
D.O.B	SEX
ADDRESS	

Use Patient I.D. label when available

PATIENT DETAILS

Title: (please tick) Mr Mrs Miss Ms	Date of Birth:
Surname:	First Name:
Previous Surname (if applicable)	
Address:	
Telephone Number:	Email :

APPLICANT DETAILS

☐ Tick if same as above

Title: (please tick) Mr Mrs Miss Ms	Date of Birth:
Surname:	First Name:
Previous Name (if applicable)	
Address:	
Telephone:	Email :

Relationship to patient:

I am both the patient and the applicant Parent Guardian Spouse or Defacto spouse Executor of the Will

Enduring Power or Guardianship Other *(specify)*

AUTHORITY TO ACCESS INFORMATION WHERE THE APPLICANT IS NOT THE PATIENT

Patient consent provided: (please tick) Below OR Separate

The patient must sign the authorisation below **or** the applicant must provide written consent from the patient or evidence of authority to amend the requested information (e.g. Enduring Power of Guardianship)

I, _____ of _____

(patient name) (patient address)

Do hereby authorise South Perth Hospital to amend my personal health information as requested by the applicant.

_____ Date: _____

(Patient Signature)

IDENTIFICATION

A **certified** copy of photo identification that shows the applicant's signature is required.
2 forms of identification are required, please refer to the Information for Applicants.

Please provide **one** of the following (please tick)

Driver's License (Australian) Passport

Plus one of the following (please tick)

Birth Certificate Medicare Card Drivers licence issued by a foreign government

Utility bill issued in the last 3 months with the applicants name and residential address (e.g. gas, electricity, water or council rates)

Please provide additional identification when the applicant is not the patient (please tick)

Enduring Power of Guardianship Letter of Authorisation Other *(specify)*

Marriage Certificate Death Certificate

REQUEST TO AMEND HEALTH INFORMATION

South Perth Hospital

Request to Access Health Information

SURNAME	UMRN
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ADDRESS	

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DETIALS OF REQUEST

Details of Amendment *Describe clearly the information you to wish to amend. Please include document title, author, dates, or any other information where possible.*

Reason for Amendment *Please tick the appropriate box to indicate why the information requires an amendment:*

Inaccurate | Incomplete | Out of Date | Misleading | Other, specify _____

Please outline the reason/s why you believe the information is inaccurate/incorrect/out of date/misleading:

Form of Amendment *Please tick the appropriate box*

Alteration | Insertion | Insert a file note

I confirm that all details on this form are correct.

Applicant's Signature: **Date:**

On completion, this form can be posted (South Perth Hospital, ATTN Health Information Manager, PO Box 726 COMO WA 6952) or emailed to: info@sph.org.au (marked ATTN Health Information Manager).